BLUE SHIELD MEDICAL PLAN COMPARISON CHART

	Blue Shield Signature HMO	Blue Shield Access+ HMO
Deductibles/Maximums		
Calendar year (CY) Deductible	None	None
Out-of-Pocket annual maximum (Some benefits excluded from the OoP maximum, refer to EOC for details)	$1,500 individual $3,000 family	$3,500 individual $7,000 family
Office/Outpatient Care		
Office visits	Level I - $10 copay Level II - $30 copay	$40 copay. Self-referral within PCP's Medical Group $50
Preventive Services	No charge	No charge
Specialists	Level I - $10 copay Level II - $30 copay	$40 copay. Self-referral within assigned Medical Group $50
Emergency Medical Care		
Emergency room	$75 copay (waived if admitted)	$50 copay (waived if admitted)
Urgent care	$10 copay	$40 copay
Diagnostic Services		
Laboratory and Pathology Tests	Level I - No Charge Level II - Covered only when performed in physician's office	You pay 40%
Diagnostic Tests and X-Ray	Level I - No Charge for CT, MRI, MUGA, PET. and SPECT Level II - Covered only when performed in physician's office	You pay 40%
Hospital Services		
Hospital care (Physician and Facility charges)	No charge	$100/admission plus 20% for facility services. Physician services - no charge

***Member pays Calendar Year (CY) deductible before Blue Shield pays for covered services under the benefit plan**

Please note: This comparison chart only highlights benefits. The evidence of coverage document (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this comparison chart and the official plan documents, the official plan documents will prevail.

	Blue Shield Trio HMO	Blue Shield PPO	
		In-Network	Out-of-Network
Deductibles/Maximums			
Calendar year (CY) Deductible	None	$250 individual. $500 family	
Out-of-Pocket annual maximum (Some benefits excluded from the OoP maximum, refer to EOC for details)	$3,500 individual $7,000 family	$1,750 individual $3,500 family	$2,250 individual $4,500 family
Office/Outpatient Care			
Office visits	$25 copay. Self-referral within PCP's Medical Group $25	$10 copay (CY deductible waived)	You pay 30%*
Preventive Services	No charge	No charge (CY deductible waived)	You pay 30%*
Specialists	$25 copay. Self-referral within PCP's Medical Group $25	$10 copay (CY deductible waived)	You pay 30%*
Emergency Medical Care			
Emergency room	$50 copay (waived if admitted)	$50 per visit + 20%* ($50 waived if admitted) ER Physician Services: You pay 20%*	$50 per visit + 20%* ($50 waived if admitted & treated as in-network benefit). ER Physician Services: You pay 20%*
Urgent care	$25 copay	$10 copay (CY deductible waived)	30% after CY deductible
Diagnostic Services			
Laboratory and Pathology Tests	You pay 40%	You pay 20%*	You pay 30%*
Diagnostic Tests and X-Ray	You pay 40%	You pay 20%*	You pay 30%*
Hospital Services			
Hospital care (Physician and Facility charges)	$100/admission plus 20% for facility services. Physician services - no charge	You pay 20%*	You pay 30%*

BLUE SHIELD MEDICAL PLAN COMPARISON CHART *(CONTINUED)*

	Blue Shield Signature HMO	Blue Shield Access+ HMO
Surgical Services		
Hospital – In Patient Surgical Services	No charge (Facility and Physician services)	$100/admission plus 20%
Outpatient / Ambulatory Surgery Center	No charge (Facility and Physician services)	Facility - 40% Physician services - No charge
Mental Health Care and Substance Abuse Treatment		
Outpatient services	1-3 visits: No charge $10 per visit thereafter	$40/office visit
Inpatient services	No charge	$100/admission plus 20%
Prescription Drugs		
Prescription drugs (per fill) Includes Diabetic drugs and testing supplies	Pharmacy (30-day supply): Generic: $5 copay Brand: $10 copay Non-Formulary: $25 copay Specialty: $10 copay Mail order is voluntary 90-day supply at discounted rate Pharmacy (retail and mail order) copays do not apply toward the out-of- pocket maximum.	Pharmacy (30 day supply): Tier 1 – $5 Tier 2 – $10 Tier 3 – $25 Tier 4/Specialty – 20% copay up to a max of $200/ prescription Mail order is voluntary. 90 day supply for twice the retail copay.
Other Services		
Chiropractic care	$10 copay/visit 20 visits max annually - Medical diagnosis/ necessity required	Not covered Discount program avaliable
Physical and Occupational Therapy Speech Therapy	Level I - $10 copay Level II - $30 copay	$40 copay

***Member pays Calendar Year (CY) deductible before Blue Shield pays for covered services under the benefit plan**

Please note: This comparison chart only highlights benefits. The evidence of coverage document (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this comparison chart and the official plan documents, the official plan documents will prevail.

	Blue Shield Trio HMO	Blue Shield PPO	
		In-Network	Out-of-Network
Surgical Services			
Hospital – In Patient Surgical Services	$100/admission plus 20%	Facility: You pay 20%* Physician: You pay 20%*	Facility: You pay 30%* Physician: You pay 30%*
Outpatient / Ambulatory Surgery Center	Facility - 40% Physician services - No charge	Facility: You pay 20%* Physician: You pay 20%*	Facility: You pay 30%* Physician: You pay 30%*
Mental Health Care and Substance Abuse Treatment			
Outpatient services	$25/office visit	Outpatient: 1–3 visits: No charge $10 per visit thereafter (Not subject to the Calendar-Year Deductible)	You pay 30%*
Inpatient services	$100/admission plus 20%	You pay 20%*	You pay 30%*
Prescription Drugs			
Prescription drugs (per fill) Includes Diabetic drugs and testing supplies	Pharmacy (30 day supply): Tier 1 – $5 Tier 2 – $10 Tier 3 – $25 Tier 4/Specialty – 20% copay up to a max of $200/ prescription Mail order is voluntary. 90 day supply for twice the retail copay.	Participating Pharmacy: $15 generic formulary $30 brand formulary $30 non-formulary Specialty Pharmacies: $15 per prescription (up to a 30-day supply) Mail order is voluntary 90 day supply at discounted rate	Non-Participating Pharmacy: 25% of billed amount plus co-pay Pharmacy: $15 generic formulary $30 brand formulary $30 non-formulary Specialty Pharmacies: Not covered Mail order not covered
Other Services			
Chiropractic care	Not covered Discount program avaliable	You pay 20%*	You pay 30%*
		Up to 30 visits per calendar year combined PPO/Out-of-Network maximum	
Physical and Occupational Therapy Speech Therapy	$25 copay	You pay 20%*(CY deductible waived)	You pay 30%*